

DOCUMENT RESUME

ED 304 750

EA 020 728

AUTHOR Gardner, Dan; Buechler, Mark
TITLE School Based Health Clinics. Policy Memo Series No. 4.
INSTITUTION Consortium on Educational Policy Studies, Bloomington, IN.
SPONS AGENCY Indiana Univ., Bloomington. School of Education.; Lilly Endowment, Inc., Indianapolis, Ind.
PUB DATE Jan 89
NOTE 37p.
AVAILABLE FROM Publication Sales, Consortium on Educational Policy Studies, School of Education, Suite 326, Bloomington, IN 47405 (\$2.50).
PUB TYPE Reports - Research/Technical (143)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; *Clinics; *Educational Finance; Elementary Secondary Education; Family Planning; Federal Aid; *Health Education; *Health Facilities; *Health Programs; *Health Services; High Schools; Legislation; Medical Services
IDENTIFIERS Indiana; *School Based Clinics

ABSTRACT

In response to a growing public awareness of health problems faced by America's teenagers, a number of high schools are establishing health clinics for students inside or near the school. School-based clinic staff and services vary depending on levels of funding, state laws, and community standard. To pay for services, clinics rely on both public funds and private financing. In 1986 and 1987, legislation was introduced in both houses of the U.S. Congress that would have provided direct federal aid to school-based health clinics. However, the legislation died in committee, and no new legislation was introduced in 1988. Like all other midwestern states except Iowa, Indiana is the home of several school-based clinics, four of which are described in the paper. School-based clinics often spark intense local controversy concerning the issue of family planning. Appended are 27 references. (SI)

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SCHOOL-BASED HEALTH CLINICS

Policy Memo Series No. 4 January 1989

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The authors wish to thank the directors of all school-based health clinics mentioned in this paper for their cooperation in providing information and assistance.

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SCHOOL-BASED HEALTH CLINICS

In an increasing number of school districts across the nation, the doctor is in. And he or she may be seen conferring not only with a nurse, but also with a psychologist, a nutritionist, a dentist, a laboratory technician, and/or a social worker. The setting for this assortment of health care professionals is the SCHOOL-BASED CLINIC.

The reason for the popularity of this new concept in adolescent health care is the growing public awareness of health problems faced by this nation's teenagers. Consider, for example, these findings of the American Medical Association (AMA):

- Two thirds of high school students have used an illicit drug.
- One fifth of high school seniors smoke cigarettes daily.
- As many as 10% of teenage girls suffer severe eating disorders.
- 46% of unmarried women who give birth are teenagers.
- One half of all rape victims are under the age of 18.
- 6% of all boys and 15% of all girls are sexually abused by the time they reach 16.
- In cases of physical abuse, 24% of all fatalities and 41% of all serious injuries happen to 12- to 17-year-olds.
- Each year, at least 5,000 people 18 or under commit suicide, and at least 50,000 attempt to do so.

(AMA, 1986)

If these findings are not sufficiently alarming, the AMA (1986) also reports that both the disease and mortality rates for teenagers are 11% higher than 20 years ago (p. 29).

These distressing figures make it apparent that merely being young is no assurance of good physical health or emotional stability. Many of the health-related problems faced by youths may, in fact, be due to their age. Collectively, teenagers tend

to engage in violent and potentially dangerous behavior more frequently than do young children or adults (Lovick, 1987). In addition, teens are often the victims of health problems that result from sexually transmitted diseases. And, of course, adolescents are susceptible to the broad spectrum of physical and psychological maladies common to growth and development--from acne to identity crises--as they move toward adulthood. The AMA (1986) describes adolescence as a "distinctive and highly stressful phase" of human growth and development (p. ii).

Although teens experience a higher occurrence of acute health conditions than one might expect, they see physicians less often than any other age group (AMA, 1986, p. ii). Many low-income families cannot afford regular health care for their children (Lovick & Wesson, 1986). Transportation, scheduling, cost, paperwork, and legal consent requirements may be obstacles that decrease the willingness of teenagers to seek help on their own--even when they suspect they need it. It is also possible that young people are confused, intimidated, or even frightened in the unfamiliar and impersonal environment of a hospital or clinic.

For these and other reasons, the Center for Population Options (CPO), a Washington, DC-based organization, believes that school-based clinics offer "a promising approach to addressing the special health and social service needs of adolescents" (CPO, 1987b).¹ The rationale is simple: bring the doctor to the patient.

The staff at CPO's Support Center for School-Based Clinics in Houston, Texas is not the only group of professionals that

applauds this controversial approach to adolescent health care. Among proponents of school-based clinics are the American Psychological Association, the American Psychiatric Association, the Association of School Nurses, the National Urban League, the National Parent-Teacher Association, and the National Education Association. The SBC growth data shown in Table 1 confirm that the school-based clinic is rapidly gaining momentum as a vehicle for improving adolescent health.

Table 1. The Growth of School-Based Clinics

<u>Year</u>	<u>Number of Clinics</u> (approximations)
1970.....	1
1973.....	2
1976.....	3
1978.....	5
1979.....	9
1980.....	12
1981.....	18
1982.....	24
1983.....	28
1984.....	31
1985.....	53
1986 (Summer).....	62
1986 (December).....	76
1987 (March).....	85
1987 (October).....	101
1988 (March).....	124
1988 (August).....	138 ¹

Sources: CPO, 1987b; Dryfoos, 1988; Lovick, 1987; Lovick & Wesson, 1986; "Sites," 1988.

¹These 138 school-based clinics are operating in 30 states. Junior high schools house at least 17 of the clinics, while the rest are located in high schools (Dryfoos, 1988).

It is evident that most school health clinics have begun operations during the mid-1980s. But Support Center for School-Based Clinics director Sharon Lovick points out that while the clinic concept itself is of relatively recent origin, the partnership between medicine and education is not (Lovick, 1987). Educators and physicians share a history of combining personnel and resources to combat health problems and assure that students are in the best possible mental and physical condition to become educated and productive citizens. Pupil vaccination programs are perhaps the most familiar example. The school physical for elementary and junior high students is a long-standing practice in most, if not all, school districts. And for decades school nurses have faithfully applied bandages, soothed upset stomachs, and made certain that students receive their medications.

However, SBCs have added a new dimension to the notion of health care at school—one that stretches beyond simple immunization and first-aid into more complex areas of disease prevention and treatment. Table 2 (p. 5) discloses the range of health care options available at many of these clinics. The "ideal" SBC is a comprehensive, holistic, and multi-disciplinary health service specializing in the physical, emotional, and psycho-social needs of adolescents. While stopping far short of surgery or other complicated medical procedures, many school clinics try to be as comprehensive as their nontraditional settings and limited resources will allow.

Table 2. School-Based Clinic Health Care Options

<u>Service</u>	<u>% of SBCs Offering Service</u>
General primary health care.....	98%
Assessment & referral to community health care system.....	98%
Physicals.....	95%
Laboratory tests.....	95%
Diagnosis/treatment of minor injuries.....	95%
Assessment & referral to local physicians.....	94%
Prescribe medication for treatment.....	92%
Pregnancy detection & referral for prenatal care.....	89%
Diagnosis/treatment of sexually transmitted diseases.....	87%
Gynecological exams.....	85%
Immunizations.....	81%
Follow-up exams for birth control users.....	77%
Chronic illness management.....	75%
Dispense medication for treatment.....	72%
Examination for selected birth control methods.....	62%
Referrals for birth control method & exam.....	61%
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)...	51%
Pediatric care for infants of adolescents.....	47%
Prescribe birth control methods.....	46%
Prenatal care.....	41%
Dental services.....	41%
Daycare.....	17%
Dispense birth control methods.....	15%

Source: Lovick & Stern, 1988.

Besides the medical services listed above, all SBCs consider health education a vital clinic activity. Aimed at both body and mind, health fairs, workshops, seminars, and classroom presentations offer forums for learning and discussion about nutrition, fitness, drugs, sex, social relationships, and self-esteem. Over 75% of SBCs also provide counseling services to help treat the emotional trauma often associated with teen pregnancy, substance abuse, and peer pressure. Clinic personnel in some schools even take educational activities to their "feeder schools" in order to cultivate health awareness among the junior high or elementary students who will someday be using clinic facilities.

The number and type of clinic personnel vary considerably. Including clerical and other support personnel, the number of full-time paid staff may be as few as one or as many as fifteen. A nurse practitioner, a medical doctor, and a social worker are common. Some of the more comprehensive clinic sites may employ a nutritionist, a dentist or dental hygienist, and/or a psychologist. Pediatric and obstetric/gynecological specialists are especially desirable. Staff combinations vary, depending on the complexity of services offered and the financial resources available. It is important to point out that it is often only the volunteer and in-kind services (e.g., donated space, utilities, and staff support) of hospitals, health departments, and school districts that keep the doors of many school clinics open.

Since size, services, and staff members vary considerably from clinic to clinic, it is difficult to define the "typical"

SBC. The facts and figures in Table 3 provide a very general sketch of the school-based clinic picture.

Table 3. School-Based Clinic Facts and Figures

- Most SBCs are located in low-income urban areas, where teen pregnancy and dropout rates tend to exceed the community or national averages.
- All SBCs are located in school buildings or on school grounds.
- Almost all SBCs are open 40 hours per week, Monday through Friday.
- Almost two thirds have summer hours.
- 68% arrange for after-hours or emergency care at an area hospital, a community site, or somewhere else.
- Over one third of SBCs serve patients other than students enrolled in the home school, including dropouts, siblings and children of students, and adolescents in the larger community area.
- Almost 40% of the students at schools with clinics use clinic services at least once during the school year.
- Over three fifths of clinic users are females.
- The average clinic handles about 210 student visits each month.
- 55% of clinic users have no other primary source of health care.

Source: Lovick & Stern, 1988.

Funding and Administration

For many SBCs the broad range of staff and services listed above is only a dream. The reality is inadequate funding. While claiming effectiveness to the extent that their resources will allow, clinic administrators are painfully aware of the correlation between number of services and money. According to CPO's most recent survey of SBCs (Lovick & Stern, 1988), operational costs for school clinics range from \$10,000 to \$414,900 a year, depending on the size of the student body and the amount and types of personnel and services. The average budget per clinic is \$120,991.²

To raise these funds, clinics rely on both public and private sources. About half the clinics have a single source of income, while others depend on as many as six funding sources. As Table 4 indicates (p. 9), the majority of the fiscal burden is still carried by the taxpayer, primarily through federal Maternal and Child Health block grants (which are distributed by states), state allocations, and local budgets. However, despite an increase in state and local funding, the overall proportion of public contributions is shrinking. Meanwhile, private foundations are taking up the slack. Foundations like the Robert Wood Johnson Foundation, which supports numerous clinics nationwide, now contribute 41% of total clinic funds, up from 31% in 1986.

Usually, funding from states and private foundations is limited to "start-up" grants, which are not intended to provide long-term financial support for school-based clinics. This type of funding is adequate only for a year or two, with no assurance

of renewal. As foundation dollars dwindle or a state agency's grant cycle comes to a close, alternative sponsors must be sought. But generous and dependable benefactors are difficult to find. To date, individual and corporate sources have barely been tapped. Until they are, most school-based clinic programs will have to continue seeking foundation and public support for survival.

Table 4. Sources of Funding for School-Based Clinics

<u>PUBLIC</u>	<u>1986</u>	<u>1988</u>
State	16%	19%
MCH	27%	14%
EPSDT	14%	2%
Other Public	7%	22%
Total Public	64%	57%
<u>PRIVATE</u>		
Foundations	31%	41%
Other Private	5%	2%
Total Private	36%	43%

Sources: Lovick & Stern, 1988; Lovick & Wesson, 1986.

Notes: MCH: Maternal and Child Health block grants.
EPSDT: Early and Periodic Screening, Diagnosis and Treatment Program.
Other Public: Medicaid (2%), Title XX (1%), and a combination of city and county health budgets, community health programs, and others (19%).
Other Private: patient fees (.4%), private insurance reimbursement (.1%), and a combination of donations from private corporations, nonprofit organizations, and individuals (2%).

Whatever the source of funds, it would be a mistake to assume that they always go to the school district where the clinic is located. In fact, school districts administer only 18% of all clinics nationwide--not a large proportion, but a significant jump from just 4% in 1986 (Lovick and Wesson, 1986). According to Lovick and Stern (1988), the other clinics are administered by departments of public health (29%), nonprofit organizations (27%), hospitals/medical schools (20%), or community clinics (7%). Except in cases where the clinic is "owned" by the school district, the sponsoring agency either shares fiscal and administrative responsibilities with the district or assumes these responsibilities on its own, as per contractual agreement (Edwards & Brent, 1987).

The majority of SBCs (87%) operate under the direction of an advisory board (Lovick, 1987). The medical professionals, parents, students, and civic, church, and local health department officials that often compose these boards are responsible for raising funds, assessing student health needs, developing programs, and coordinating clinic/community-relations.

Legislative Activity

Currently, federal aid for SBCs is indirect, channeled through state governments via MCH grants. In both 1986 and 1987, legislation was introduced in the U.S. Senate and House of Representatives that would have provided \$50 million over four years in direct federal aid to local SBC programs.³ However, all four bills died in committee, and no similar legislation was reintroduced in 1988.

On the state level, SBC policy initiatives have proliferated in both the legislative and executive branches, often as a result of task force studies on teen health problems. In 1986, there were over 35 SBC policy initiatives (bills, task force recommendations, and executive branch actions), up from 13 in 1985 and zero in 1984 (CPO, 1987a).

However, state initiatives are invariably contested. The Wisconsin 1987-88 fiscal year budget, for example, provided \$1.28 million for the establishment of eight school-based clinics. But the bill fell to Governor Tommy Thompson's veto because of the possibility that the clinics would offer family planning services. In Illinois, both the house and the senate approved measures in 1987 aimed at barring SBCs from distributing contraceptives. But Governor James Thompson vetoed the legislation, and similar bills introduced in 1988 died in committee. The 1987 Michigan legislature appropriated \$1.25 million to establish additional clinics in or near schools; at the same time, it passed a law prohibiting clinics from counseling teens on abortion or distributing or prescribing contraceptives (Viadero, 1987). In California, legislation that would have matched private SBC contributions with public funds was recently defeated by one vote.

Amid this flurry of legislative activity--fueled by the political, religious, and social controversies surrounding family planning issues--a number of general questions have emerged. For instance, will government funding come with "strings attached" (i.e., with limitations or prohibitions on funding for SBCs that

prescribe or dispense contraceptives)? And if so, will such conditions be imposed at the federal level or remain state prerogatives? How will questions of parental consent and school district access to information be answered? Will medical liability problems provoke new legislation? For SBC supporters and opponents alike, the controversies at local, state, and national levels appear to be just beginning.

School-Based Clinics Around the Midwest

As the legislative controversies in Wisconsin, Illinois, and Michigan indicate, the Midwest is no stranger to the school-based clinic. Of the seven states monitored by the North Central Regional Educational Lab (Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, and Wisconsin), six have at least one SBC (only Iowa has none).

Serving students K-12, the Cleveland Student Health Program in Cleveland, Ohio relies heavily on volunteers to carry out its mission. The clinic is used by virtually all of the 1,200 or so students in the high school, and officials plan an extensive evaluation that includes tracking students for five years after graduation in an attempt to assess what impact the clinic might have had. It is worth noting the apparent popularity of the facility despite the fact that birth control devices are neither dispensed nor prescribed.

A Flint, Michigan SBC, operated by the Hurley Medical Center, has had a different experience with birth control. While never dispensing contraceptives, it had arranged for a local pharmacy to do so upon written notice from a clinic staff member. But when

Michigan's law prohibiting that practice became effective on October 1, 1987, use of the facility "dropped considerably," according to one clinic official.

Two other school-based clinics in Michigan, one in Benton Harbor and another in Port Huron, are sponsored by county health departments. A Muskegon Planned Parenthood agency sponsors an SBC in one of that area's high schools.

Minnesota houses eight school clinics, four each in Minneapolis and St. Paul. Three of those in Minneapolis are run by that city's health department. The other five are all sponsored by private not-for-profit agencies. Milwaukee Comprehensive Community Health, Inc. sponsors the only school-based clinic in Wisconsin.

In Illinois, one SBC is operated by Chicago's Cook County Hospital, another by the Illinois Department of Public Health, and three more by the Ounce of Prevention Fund.

School-Based Clinics in Indiana

Presently, there are three school-based clinics operating in Indiana: the Roosevelt Adolescent Health Project in Gary, the Arsenal Tech Teen Clinic in Indianapolis, and the Central High School Health Center in East Chicago. (Plans to establish two clinics in Elkhart were put on hold in December 1988 when then Governor Robert Orr decided to withdraw state funding from the clinics due to local controversy over family planning.) Serving student populations between 1,500 and 2,200, these three clinics seek to provide comprehensive health care through medical, nutritional, psycho-social, and health education services.⁴

Administrators in the three Indiana clinics, like their counterparts in SBCs throughout the nation, anticipate serving anywhere from 30% to 60% of students enrolled in their high schools. Clinic hours basically coincide with the school year calendar, with limited summer hours.

MCH grants are the major source of funding for Indiana's three in-school clinics (see Table 5). MCH money is appropriated one year at a time, so SBC administrators must reapply annually. Local funds, mostly from public sources, account for a relatively small percentage of clinic revenues. Additionally, in-kind services from school districts, hospitals, and nonprofit organizations help to keep Indiana SBCs operating. The Indiana State Board of Health (ISBH) is presently considering a plan that would make multiple-year funding approvals possible.

**Table 5. MCH funding for Indiana School-Based Clinics
(distributed by the Indiana State Board of Health)**

<u>School-Based Clinic</u>	<u>Fiscal Year 1988 Award</u>	<u>Requested Funding for Fiscal Year 1989</u>	<u>Recommended Funding for Fiscal Year 1989</u>
Gary	\$ 108,358	\$ 121,864	\$ 104,074
Indianapolis	\$ 109,496	\$ 109,377	\$ 109,377
East Chicago	\$ 129,772	\$ 204,026	\$ 151,206

Source: Indiana State Board of Health, 1988.

Officials at all three SBCs report an overall positive response to the health centers by students, parents, and educators. And staff members at these SBCs express a sense of satisfaction derived from knowing that they are providing important health services that many of their students would not otherwise receive. Indiana's SBCs are briefly described below.

Gary Roosevelt

Sponsored by the Gary Community School Corporation, the Roosevelt Adolescent Health Clinic--Indiana's first SBC--has been in operation since 1981. Clinic staff includes a medical director, project director, obstetric/gynecological physician, nurse practitioner, social worker, nutritionist, and secretary.

The clinic provides physical assessments and conducts diagnostic tests for diabetes, hypertension, anemia, pregnancy, and kidney and bladder infections. It also considers health education a vital component of the strategy to improve the lives of Roosevelt students. Accordingly, the clinic provides information and counseling services regarding obesity, skin care, depression, substance abuse, family planning (information and counseling only), cardio-vascular health, and nutrition.

In past years, school and clinic staff have made periodic trips to Roosevelt's "feeder schools" to teach good health care habits to younger children. School officials are in the process of designing a plan whereby the clinic's nurses, social workers, and "school screening teams" can conduct more frequent dental, nutritional, and general health assessments for these elementary and middle school students.

According to clinic director Edna S. Brown, CSNP, Roosevelt's SBC is one of 10 clinics nationwide that has been chosen by CPO for a major evaluation. This study, to be available from CPO early in 1989, will assess the impact of SBCs on teen pregnancy and other health problems (personal communication, November 14, 1988).

Arsenal Tech (Indianapolis)

A joint project of the Indianapolis Public School System and the Department of Pediatric Medical Education at Methodist Hospital, the Arsenal Tech Teen Clinic opened its doors in 1985. Arsenal Tech was a logical choice for a clinic site because the school is close to the hospital, has a large, inner-city student body, and houses the school system's Learning Center for pregnant girls.

The clinic staff consists of a nurse coordinator, nurse practitioner, dietician, social worker, and secretary. Second-year residents from Methodist Hospital, who are supervised by the project's medical director, also provide medical care two half-days per week.

The clinic's extensive medical services include laboratory screening for conditions like pregnancy, diabetes, strep throat, and venereal diseases; assessment and treatment of physical problems and sports injuries; immunization against most of the common diseases; and treatment for colds, viruses, infections, earaches, skin problems, and other ailments. Personal counseling is available for problems related to drug or alcohol abuse, emotional traumas, stress, and nutrition. To receive services,

students must complete and return a parental consent form.

Referrals are made for services not provided by the clinic.

In addition to their concern for the physical and emotional well-being of students, clinic manager Marianna Bridge and her staff also hope to increase teacher and parent awareness of teen health needs and, ultimately, to improve student attendance and reduce the school's dropout rate (personal communication, November 9, 1988).

East Chicago Central High School

The East Chicago Central High School Health Center, sponsored by the School City of East Chicago, began operation early in 1988. According to project director Sue Gervais, some members of the community initially resisted the establishment of a school health center. But now that the center has opened, protest has all but disappeared as parents have seen the valuable services students are receiving (personal communication, November 11, 1988).

Also a comprehensive SBC, this center offers medical services similar in nature and scope to those of the school health clinics in Gary and Indianapolis. Counseling and information about health care are also available. These services are provided on a self-referral appointment basis. Clinic staff consists of a medical director, project director, nurse practitioner, social worker, nutritionist, and secretary/medical resource clerk.

Elkhart: Clinics on Hold

When the results of a 1986 teens-at-risk health survey revealed that Elkhart students fell below the national average, concerned educators and citizens began exploring SBCs as a

possible means to improve the health status of area teenagers. Eventually they decided to establish a clinic at each of Elkhart's two high schools (both to be administered by the Oaklawn Mental Health Center). After the ISBH approved Elkhart's grant, officials of the Elkhart Community School Corporation anticipated that the clinics would open during the 1988-1989 school year.

However, these plans have suffered a major setback. The problem was local controversy over birth control counseling and the parental authority that such counseling allegedly compromises. By law, Indiana SBCs may not dispense contraceptives (Indiana Code, 1988).⁵ Going one step further than state law, Elkhart officials had hoped to gain support for the clinics by excluding birth control counseling altogether and offering only pregnancy testing and referrals. Nevertheless, opponents feared that once the clinics were in operation, birth control services would soon follow. Opposition was vocal enough that in September 1988, Governor Orr directed the ISBH to withhold funding until opponents had a chance to air grievances at two public forums.

After the second forum on Dec. 5, 1988, Governor Orr decided to withdraw state funding from Elkhart's clinics, explaining that without full local support a clinic would prove too divisive to serve the interests of the community. However, school officials like Mary Ann Longbrake, Coordinator of the Teen Parent Program at Elkhart Community Schools, believe that opposition to the clinics comes from a small but vocal minority, and that the majority of parents with children in the schools favor the clinics (personal communication, December 12, 1988). At this point, officials have

not decided whether to resubmit their proposal to current Governor Evan Bayh, seek funds from another source, or scrap clinic plans altogether.

Taking Sides

As the controversy at Elkhart indicates, school-based clinics have the potential to split communities into warring factions, and the debate almost always revolves around family planning. The term "family planning" itself sparks debate, probably because, as a former school board member in Virginia points out, it merges religion, politics, and sex. The discord resulting from a proposed SBC in this board member's district ended in what she described as a "rhetorical meltdown" (Cook, 1987).

Words are indeed being exchanged. In spite of claims by CPO and others that abstinence is a central part of the sexual-counseling process, groups such as the National Right to Life Crusade insist that in actual practice family planning amounts to little more than a brief stop on the way to the abortion center (Glasow, 1988).

Claims and Counterclaims

Supporters maintain that because of their convenience, accessibility, and minimal cost, SBCs can provide family planning services that adolescents would probably not otherwise receive (46% of all SBCs prescribe birth control methods and 15% distribute them). Further, no matter how strongly abstention is encouraged, some teens will continue to experiment sexually, so it makes sense to provide knowledge of and access to modern methods of pregnancy and disease prevention. Agreeing with this point of

view, the National Research Council issued an "unusually bold" report in 1986 advocating the widespread distribution of contraceptives to teenagers through school-based clinics (Viadero, 1986).

Advocates point to various research studies to support their contention that SBCs reduce pregnancy and birth rates by instructing students in birth control methods--without increasing sexual activity. One 3-year study of ten SBCs indicated that their family planning programs did not cause an increase in the sexual activity of the teens who participated (CPO, 1987b).

Another 3-year study of an inner-city Baltimore clinic found a 30% decline in the pregnancy rate at the school that housed the clinic, compared with a 58% increase in other area schools during the same period. Moreover, students attending the clinic became sexually active 7 months later on average than their peers in schools without clinics (Bridgman, 1987). School clinics frequently report drops of 50% or more in birth rates among teenage girls at schools that house clinics (see Bridgman, 1987; CPO, 1987b; Kirby, 1985).

Opponents counter that SBC family planning may indeed lower the birth rate--but not the pregnancy rate. Glasow (1988) has criticized the Baltimore study (which found significantly lower pregnancy rates) because of its small sample size. Opponents also point to a nationwide study conducted by Stan Weed (1986), who concluded that even as the birth rate among teenage family planning clients decreased, the pregnancy rate increased slightly. In addition, the number of abortions increased by about

120 per 1000 clients. Although SBC proponents question the accuracy of Weed's data (see Rosoff, 1986; The Alan Guttmacher Institute, 1986; and Wattleton, 1986), clinic opponents believe this study lends credence to Glasow's (1988) claim that family planning simply encourages pregnant teens to get abortions.

Not surprisingly, the Roman Catholic Church, many of the so-called "fundamental-evangelical" religious groups, and conservative organizations like Phyllis Schlafly's Eagle Forum, the Family Research Council, and Concerned Women of America have joined the National Right to Life Crusade in condemning what they perceive as the abortion-promoting activities of school-based clinics. Abortion, however, is just one aspect of a more general breakdown in traditional morality that clinics foment, according to groups such as these. They claim that showing kids how to use birth control flies in the face of Judeo-Christian values by tacitly encouraging sexual promiscuity. Such practices are, in the words of former Secretary of Education William Bennett, "an abdication of moral authority" that says "we give up on teaching you right and wrong" (Bridgman, 1987, p. 19).

The proper source of moral authority, these groups argue, is parents. Clinic foes believe that the entire school health care notion undermines parental authority by allowing adolescents access to sensitive and controversial information and services which are beyond parental control. Clinic proponents counter that written parental permission is a prerequisite for receiving family planning or, for that matter, any other clinic service. What's more, proponents note that many SBCs actively involve parents in

their children's health care via parent advisory boards, parent-child activities, workshops, clinic tours, and home visits (Bridgman, 1987).

Glasow (1988), however, accuses clinic officials of "trivializing" parental involvement by using vague and often blanket consent forms that apply to all clinic services, or by assuming parental permission unless the parents sign a statement specifically withdrawing it (see also Dryfoos, 1985). Patrick Fagan, Executive Vice President of the Free Congress Education and Research Foundation in Washington, DC, refers to the parental-permission defense as "a public relations ploy" and insists that parents have "absolutely no rights" once their children are inside the clinic (Bridgman, 1987, p. 21).

Whatever the merit of these various arguments pro and con, a somewhat broader school-based clinic issue concerns the overlap between educational policy and social policy. In essence, is it a legitimate role of public schools to be involved in public health care? Former Secretary of Education William Bennett holds that concern with complex adolescent health issues saps administrator and teacher time, resources, and energy and only serves to distract personnel from the educational mission that local districts are in business to fulfill (Richburg, 1986). Clinic proponents argue, however, that the recognized link between poor health and school dropouts (and the subsequent individual and social problems associated with dropping out) more than justifies public school intervention in health care (Dryfoos, 1988).

Public Support?

In the face of all these claims and counterclaims, what does the public think? Clinic opponents cite a 1985 Harris poll as a "clear demonstration" of public opposition to the school/family planning connection. Glasow (1988) notes that 52% of those who had children ages 6 to 18 supported a federal law to prohibit family planning clinics from giving birth control assistance to teens without parental permission; 54% of blacks and 56% of hispanics favored such a law. And in a 1986 Harris poll, very few (12%) of the 1,000 teens surveyed believed that clinics distributing contraceptives should be located inside schools; 28% believed that such clinics should be close to schools, and 49% thought they should be somewhere else (Hume, 1986).

The Center for Population Options, however, maintains that the trend around the country is one of support for SBCs--including the family planning component. Ironically, that organization calls attention to the same 1985 Harris poll cited by opponents, indicating that 67% of all adults surveyed favored requiring schools to establish links with family planning clinics so teenagers could learn about--and obtain--contraceptives (Bridgman, 1987). In New York City, 98% of the parents of students in schools with clinics wanted a clinic in their child's school; 85% believed the clinic should provide family planning counseling; and 61% wanted the clinic either to dispense or prescribe contraceptives (Dryfoos, 1988). In another poll, 57% of 716 administrators surveyed by the Education Research Group favored

providing students with birth control as part of comprehensive school-based health services (Buie, 1987).

Even if CPO is accurate in its claims about majority opinion, there remain large and often influential pockets of resistance across the nation. Viadero (1987) offers a number of cases in point. Conceding the value of drug prevention and other SBC programs, one superintendent reported that his district would reject a clinic because of the family planning issue alone. In San Diego, one school district's attempt to establish an SBC failed for that very reason. And even though a Dade County, Florida school board had already approved a Johnson Foundation grant to open a school-based clinic that would dispense contraceptives, Governor Bob Martinez ordered state officials to reject the grant because a state agency would be administering the clinic. (Subsequently, a local agency agreed to operate the clinic, and it opened in November, 1988.)

* * *

In short, many proposed clinic sites around the country are sources of intense controversy, placing schools in what Scott Thomson, executive director of the National Association of Secondary School Principals, calls a "no-win situation" (Glasow, 1988, p. 75). Unfortunately, it is difficult to meet the challenges of improving adolescent health without confronting the realities of teen sexuality and pregnancy. It is even more difficult to reach a consensus, or even find some satisfactory middle ground, concerning intervention strategies, given the significant religious and philosophical issues involved. When

the National Right to Life Crusade is in the ring with the Planned Parenthood Federation of America, only one thing is certain: the bout is sure to be long and fierce.

Conclusion

Controversial as school-based clinics may be, an increasing number of school districts are asking the doctor in. School-based clinics are not out to replace or compete with more traditional public health care agencies. Rather, their goal is to place themselves in the best location to reach teens-in-need who for one reason or another would not seek help on their own. Students use school-based clinics because they are convenient, affordable, and as comprehensive as funding allows.

Are school-based adolescent health clinics a faddish social service trend, or will they soon be accepted as a regular health care component of many school systems? The growth figures notwithstanding, their advent is too recent to draw definitive conclusions. But given the myriad problems teens face as they move through today's public schools, continued exploration into the potential benefits of school-based clinics seems warranted.

Notes

¹A substantial portion of the data and information presented in this report was extracted from several publications of the Support Center for School-Based Clinics, a project of the Center for Population Options. CPO is funded by private individuals and foundations.

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²These budget figures do not include in-kind contributions because many programs could not calculate a dollar amount for in-kind resources. Of the 47 clinics that did report them, in-kind contributions ranged from \$2,200 to \$213,219, with an average per clinic of \$42,950.

³Senator Paul Simon (D-IL) sponsored S. 2757 in 1986 and the identical bill S. 737 in 1987. In the House of Representatives, the 1986 sponsors of H.R. 5377 were:

Congressman Henry Waxman (D-CA)
Congressman George Miller (D-CA)
Congressman Chester Atkins (D-MA).

H.R. 1609 was introduced in June of 1987 by the Subcommittee on Health and the Environment--the full committee is Energy and Commerce. A transcript of that hearing is available upon request (document #100-80).

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⁵IC § 25-22.5-1-2.19c says "A person described in subsection (a)(7) [any school corporation and any school employee] shall not be authorized to dispense contraceptives or birth control devices."

Depending on the interpretation of "school corporation" and "school employee," it appears that clinic personnel at Arsenal Tech might be able to dispense contraceptives without violating the law, since they are employees of the sponsoring hospital rather than of the school corporation itself.

However, it seems clear that the intent of the law was to prevent school-based clinics from dispensing contraceptives, and,

barring legal challenge, this will no doubt be its effect (Sandra Bickel, legal analyst for the Indiana Department of Education, personal communication, Nov. 29, 1988). None of Indiana's clinic directors has expressed any interest in defying this restriction on birth control services.

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